VALENCIA CHIROPRACTIC

Self-pay / Insurance Questionnaire:

Name: _____ Age: _____ Date of birth: _____ Date: _____

Address: _____ Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____ Cell Phone: (_____) _____

Home: (_____) _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: ☐ M ☐ S ☐ W ☐ D Spouse's Name: _____ Spouse's Phone: (_____) _____

In case of emergency, notify _____ **Relationship:** _____ **Phone (_____)** _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

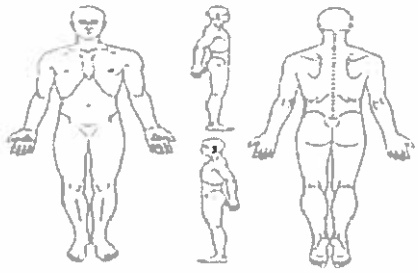
What makes your symptoms **better**? _____ What makes your symptoms **worse**? _____

Are your symptoms local or do they move to another area? (If they move, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent **<25% of your waking hours**

Please mark on the diagram to the right the following abbreviations as they relate to your symptoms:

ST = stiffness	SH = shooting pain
DP = dull pain	TI = tingling
SP = sharp pain	NU = numbness
SS = spasms	O = Other



Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ **Yes** ☐ **No;** First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____

The patient is under 18 years of age: ☐ Yes ☐ No; Parent/ Guardian name: _____

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(520) 294-2282

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Patient's Name: _____ Date: _____

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

Please list any recent X-rays, lab or other tests:	**Date**	**Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

Tuberculosis ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No	Stomach/Ulcer ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No
Sciatica ☐ Yes ☐ No	Blood Pressure ☐ Yes ☐ No	Transfusion ☐ Yes ☐ No	Polio / MS ☐ Yes ☐ No
Colon Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No	Cancer ☐ Yes ☐ No	Bleeding ☐ Yes ☐ No
Paralysis ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No	Asthma ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No	Drug Dependence ☐ Yes ☐ No	AIDS ☐ Yes ☐ No

Any other condition(s) not listed above that the doctor should be made aware of:

_____

HIPAA Compliance

Valencia Chiropractic is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

How did you hear of our office? _____

Like us on **Facebook**

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Informed Consent

Dr. Verant will use either his hands or an instrument or both to move the joints of your body; this may result in an audible "pop or "click". As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

The treatments used at Valencia Chiropractic include but are not limited to: Ice, Vibratory Massage, Intersegmental Traction, Diathermy, Electric Muscle stimulation and Ultrasound. Risks involved with the recommended ancillary treatments: Ice can cause burning. Intersegmental traction and vibratory massage can cause temporary post-treatment soreness or reflex muscle spasms. Neuromuscular reeducation may cause soreness or sprain/strain symptoms. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure or the anesthesia.

Note that chiropractic is a natural healing art, and many times one treatment does not fully restore one's body completely to health. Usually multiple treatments are necessary to feel the benefit of chiropractic treatment. Likewise, there are some ailments that chiropractic cannot "cure", but instead may help treat symptoms. Ultimately, be aware that one must fully present their medical history in order for Dr. Verant to judge if chiropractic treatment is safe or could benefit your health.

Do not sign until you have read and understand the above

I have read the above explanation of the chiropractic adjustment and the related treatment. By signing below I verify that I have weighed the risks involved in chiropractic care and that I have provided all of my medical history necessary to aid in my treatment or to avoid injury. Having been informed of the risks, I hereby give my consent to treatment.

Patient Name_____ Date_____

Patient Signature_____

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Assignment of Benefits

Financial Responsibility:
I have requested treatment from Valencia Chiropractic/ Dr. Michael E. Verant, D.C. on behalf of myself and/ or my dependents, and understand that by making this request I am responsible for all charges incurred. I understand that all fees for said services are due immediately in full upon presentation of the appropriate statement unless other arrangements have been made in advance. I understand that if my case is not covered by insurance or an attorney for any reason, I am responsible for any and all balances incurred at Valencia Chiropractic.

I am aware that if any outstanding balances are incurred at Valencia Chiropractic, I will be sent a letter by mail and have the option to: (1) send payment through mail, (2) pay over the phone with an additional fee of $1.00 per transaction or (3) pay in person. If three letters regarding an outstanding balance have been mailed to me, and I have not made an effort to pay my balance, I am aware that my balance will be sent to a collection agency or possibly pursued in small claims court. The third letter mailed to me will present a deadline for payment of my total balance. Also, I understand that it is my responsibility to make Valencia Chiropractic aware of any address or personal information changes. If a letter regarding an outstanding balance is returned to Valencia Chiropractic due to an incorrect address, Valencia Chiropractic will attempt to contact you by telephone. If ten (10) days pass without an effort made to pay the balance, the account will be turned over to our collection agency or possibly pursued in small claims court. Once in the collection agency, I understand that I forfeit my opportunity to pay Valencia Chiropractic directly, and any discounts shall not be honored.

Assignment of Insurance Benefits:
I hereby assign all applicable health insurance and other insurance benefits to which I and/ or my dependents are entitled to Valencia Chiropractic. I certify that the health insurance and other insurance information that I provided to Valencia Chiropractic is accurate as of the date set forth below and that I am responsible for keeping it updated.
I hereby authorize Valencia Chiropractic to submit claims to: _____ on my and/ or dependents
(Insurance company)
behalf, to the insurance (or its administrator) listed on the current insurance I provided to Valencia Chiropractic, in good faith. I also hereby instruct my insurance (or its administrator) to pay Valencia Chiropractic directly for services rendered to me or my dependents.

I am fully aware that having health insurance or the insurance I provided does not absolve me of my responsibility to ensure that my balance at Valencia Chiropractic is paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, vehicle insurance, including co-payments, co-insurance, deductibles, Etc… I am ultimately aware that my insurance benefits are verified prior to treatment, but this does not guarantee payment upon their receipt of the claim.

_____ _____
Patient (print name) Date

_____
Signature

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